U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue date: 18Jan2002

CASE NO.: 1996-BLA-1028

In the Matter of:

ROBERT SHUMAN
Claimant

v.

CONSOLIDATION COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

DECISION AND ORDER ON REMAND–DENYING BENEFITS

This matter is before me on remand from the Benefits Review Board ("Board") pursuant to its Decision and Order (BRB No. 99-1254 BLA), which was issued on November 17, 2000.

Procedural History

Claimant filed his first claim for benefits on August 29, 1978. (DX 27)[1] It was finally denied by the Benefits Review Board on December 30, 1982. (DX 27) Claimant filed his second claim for benefits on June 15, 1995. (DX 1) I awarded benefits by Decision and Order dated January 7, 1998. Following Employer's timely appeal, on March 10, 1999 the Benefits Review Board issued a Decision and Order affirming my decision in part, vacating in part, and remanding for further consideration consistent with its opinion. (BRB No. 98-0624 BLA) On August 16, 1999, I issued a Decision and

[1] The following abbreviations may be used herein as citations to the administrative record: DX = Director's exhibits; CX = Claimant's exhibits; EX = Employer's exhibits; JX = joint exhibit of the parties; D&O = January 7, 1998 Decision and Order; and D&OR = August 16, 1999 Decision and Order on Remand.

Order awarding benefits on remand. Employer appealed and on November 17, 2000 the Board vacated the award of benefits and remanded the case for further consideration consistent with its opinion. Claimant thereafter appealed further, to the United States Court of Appeals for the Fourth Circuit, and on April 12, 2001 the Court granted Employer's Motion to Dismiss.

Mandate on Remand

In its March 10, 1999 Decision and Order, the Board affirmed my initial finding of pneumoconiosis based solely upon the x-ray evidence. Subsequently, in *Island Creek Coal Co v. Compton*,[2] the Fourth Circuit held that the ALJ must weigh all the evidence relevant to the existence of pneumoconiosis together, rather than within discrete subsections of § 718.202(a). Thus, all types of relevant evidence such as x-rays and physicians' reports must be weighed together in determining whether a claimant has pneumoconiosis.

I am instructed to "reweigh the medical opinion evidence at subsection (a)(4)" and provide valid reasons for the relative weight accorded to the opinions. In this most recent Decision and Order, the Board noted that I made some of the same errors in finding pneumoconiosis established by the medical opinion evidence on remand, as I did in finding causation in my original Decision and Order. Specifically, these errors were: 1) that I "mechanistically discredited Dr. Fino's opinion because he did not personally examine the claimant;" (BRB No. 98-0624 BLA at 5) 2) that I "incorrectly found that the pulmonary interstitial fibrosis diagnosed by Dr. Renn is part of the legal definition of pneumoconiosis" and it was error to find this (*Id.*); 3) according little weight to the opinion of Dr. Altmeyer "due to his admitted unfamiliarity with the manifestation of pneumoconiosis in the lungs," was "irrational and not supported by the record." (*Id.* at 6, *citing* ALJ Decision and Order of January 7, 1998). Therefore, I am to take these errors into consideration when reweighing the medical opinion evidence at subsection (a)(4).

In addition, if I find the existence of pneumoconiosis, I must then determine whether Employer has rebutted the § 718.203(b) presumption that the pneumoconiosis arose out of coal mine employment in light of its decision in *Cranor v. Peabody Coal Co*.[3] Therefore, I am instructed to "consider whether the comments of Drs. Renn, Fino, Wiot, and Altmeyer support a finding of rebuttal pursuant to Section 718.203(b)." Finally, if I find the existence of pneumoconiosis on remand, I must consider whether it "is at least a contributing cause of Claimant's totally disabling respiratory impairment."

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[2] 211 F.3d 203 (4th Cir. 2000).

[3] In *Cranor v. Peabody Coal Co*., 22 B.L.R. 1-1, 1-4-6 (1999)(*en banc*), the Board held that physician comments indicating that the source of pneumoconiosis, while not relevant to the issue of existence, are relevant to whether the pneumoconiosis arose out of coal mine employment. This decision was issued after the filing of briefs in this appeal.

Findings of Fact and Conclusions of Law

Except as otherwise vacated by the Benefits Review Board, or modified herein, all of the evidence which was previously discussed in the Decision and Order–Awarding Benefits, issued January 7, 1998, as partially affirmed by the Benefits Review Board, is incorporated by reference. As set forth above, the threshold issue is whether Claimant has established the existence of pneumoconiosis pursuant to *Compton*. The Board affirmed my finding of the existence of pneumoconiosis by the x-ray evidence; therefore, I have reweighed the medical opinion evidence at subsection (a)(4), considered the errors in finding pneumoconiosis discussed by the Board and set forth above, and weighed it together with the x-ray evidence.

Medical Opinions

Dr. Devabhaktuni, director of the pulmonary lab and respiratory therapy at Fairmont General Hospital, examined the miner and offered an opinion. (DX 10) He concluded that Claimant suffers from chronic obstructive pulmonary disease and pneumoconiosis due to his long history of smoking and occupational dust exposure; hypertension; history of pulmonary thromboemboli; moderate impairment due to pulmonary disease, most impairment due to CVA; moderate impairment due to chronic obstructive pulmonary disease. He recorded a smoking history of 11/2 packs per day from 1932 to December 1994.

Dr. Altmeyer, also board certified in pulmonary medicine and a B-reader, submitted a consultative opinion on May 20, 1996 and a supplemental consultative opinion on June 21, 1996. (EX 6, 7) Dr. Altmeyer first concluded that it is likely the miner has simple coal workers' pneumoconiosis; moderate, and at times, severe degree of air flow obstruction which is unrelated to his simple cwp, but is directly related to pulmonary emphysema as a result of long term cigarette smoking; on the basis of his total respiratory impairment, he would be prevented from performing any heavy, repetitive, manual labor in the coal mines; and there is no significant component of the miner's impairment related to his pneumoconiosis. In his supplemental consult rerort, Dr. Altmeyer concluded that there is insufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis; the chest x-ray is not at all consistent with coal workers' pneumoconiosis; Claimant does have a significant respiratory impairment, but that impairment is not attributable to dust exposure or pneumoconiosis; however, it would prevent him from performing any heavy, repetitive, manual labor in coal mines. Dr. Altmeyer explained that the change in his opinion resulted from his increased experience in pulmonary medicine from his 1979 opinion[4] and that subsequent to his May 1996 opinion, he was provided additional x-rays and was, therefore, able to review the entire series of x-rays, which allowed him to come to a different conclusion. (EX 7)

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[4] At the time he gave this opinion, Dr. Altmeyer was a pulmonary fellow and was not board certified in pulmonary medicine nor a NIOSH Certified B reader.

Dr. Renn, board certified in pulmonary medicine and a B-reader, examined the miner on two occasions and submitted a report dated March 17, 1996. He recorded a smoking history of 1-1/2 packs per day from 1934 to 1981. He opined that the miner has chronic bronchitis-emphysema complex, idiopathic pulmonary interstitial fibrosis, increased dorsal kyphosis, residual right hemiparesis owing to left hemispheric cerebrovascular accident complicated by seizures, arteriosclerotic coronary vascular disease manifested by angina pectoris, arteriosclerotic peripheral vascular disease, and chronic congestive heart failure and systemic hypertension. He does not have pneumoconiosis. He has an obstructive ventilatory defect and impairment of diffusion of sufficient degree to prevent him from being able to perform his last known coal mining job. Dr. Renn concluded, to a reasonable degree of medical certainty that Claimant's chronic bronchitis-emphysema complex, idiopathic pulmonary interstitial fibrosis, increased dorsal kyphosis, residual right hemiparesis, arteriosclerotic coronary vascular disease, arteriosclerotic peripheral vascular disease, and chronic congestive heart failure and systemic hypertension were neither caused, nor contributed to, by his exposure to coal mine dust and it is within a reasonable degree of medical certainty that Claimant's chronic bronchitis-emphysema complex resulted from his years of tobacco smoking rather than exposure to coal mine dust.

Dr. Fino, a board-certified pulmonologist and B-reader offered a consultative opinion dated July 10, 1996. (DX 9) He concluded that Claimant does not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure based upon the fact that: 1) the majority of x-rays were either negative or, if read positive, showed irregular opacities affecting the lower lung zones. He noted that the presence of only irregular opacities in the absence of rounded opacities is inconsistent with the diagnosis of coal workers' pneumoconiosis; 2) the obstructive ventilatory abnormality shows an involvement of the small airways and on a proportional basis, the small airway flow is more reduced than the large airway flow, which is not consistent with a coal related condition but is consistent with cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma. Dr. Fino also notes that while pneumoconiosis "may be progressive," in this case there is no progression in the chest x-ray, yet significant progression of obstructive ventilatory abnormality in the presence of further smoking but in the absence of further coal mine dust exposure, indicating that the obstructive abnormality is most consistent with cigarette smoking; 3) the miner's elevated lung volumes is typical of individuals with obstructive lung diseases such as emphysema, asthma, chronic obstructive bronchitis but this pattern is not consistent with the contraction of lung tissue due to fibrosis as would be expected in simple coal workers' pneumoconiosis; the reduction in the diffusing capacity is way out of proportion to pneumoconiosis. Dr. Fino opined that this reduction can be attributed to pulmonary emphysema due to cigarette smoking or the miner's repeated bouts of aspiration pneumonia; 4) improvement of the May 30, 1995 arterial blood gases suggests a reversible type of lung condition; 5) the significant variability in the physician examination findings of rales, wheezes, and rhonchi are not consistent with coal mine dust inhalation but are consistent with cigarette smoking.

The regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding the claimant has pneumoconiosis as defined in § 718.201. See § 718.202(a)(1)-(4). As there is no autopsy evidence or biopsy evidence in this case and claimant is not eligible for the enumerated presumptions, he must rely on chest x-rays and medical opinions to establish the existence of pneumoconiosis.

As noted previously, the Board affirmed my finding that pneumoconiosis was established by x-ray; therefore, I must now reweigh the medical opinion evidence to determine if it establishes the existence of pneumoconiosis. Then, pursuant to *Compton*, I must weigh the x-ray and medical opinion evidence together to determine whether the claimant has pneumoconiosis.

Four physicians offered medical opinions as to the existence of pneumoconiosis. Dr. Devabhaktuni concluded that the miner suffers from chronic obstructive pulmonary disease and coal workers' pneumoconiosis due to both his extensive smoking history and his long term coal mine dust exposure. Drs. Altmeyer, Renn, and Fino, on the other hand, concluded that the miner does not have pneumoconiosis. Drs. Altmeyer and Renn both examined the miner and also subsequently reviewed his medical records. Dr. Fino did not examine the miner but provided an extensive review of his records.

An unreasoned opinion may be given little or no weight. *Clark v. Karst-Robbins Coal* Co., 12 B.L.R. 1-149 (1989 en banc). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19 (1987). A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician has based the diagnosis. *Fields, supra*. An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction* Co., 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127 (1987). Indeed, whether a medical report is sufficiently documented and reasoned is for the judge as the finder of fact to decide. All of the physicians based their conclusions on the miner's work and social histories, in addition to ventilatory and blood gas studies; therefore, I find that all of them are well-documented.

In my original Decision and Order, I accorded Dr. Altmeyer's opinion less weight based upon his "admitted unfamiliarity with the manifestation of pneumoconiosis in the lungs." (Decision and Order–Awarding Benefits at 17). Dr. Altmeyer, however, explained in his final supplemental report that he subsequently concluded that the miner does not have pneumoconiosis after he was able to review the series of chest x-rays which were taken over a number of years. He based this conclusion on the "slow but progressive development of primarily irregular opacities at the bottom of the lung, which is not consistent with pneumoconiosis." (EX 12) I find Dr. Altmeyer's opinion to be a reasonable one in light of the medical evidence of record and I accord it greater weight.

I also accorded Dr. Renn's opinion less weight, and I erred in my original Decision and Order by finding the pulmonary interstitial fibrosis diagnosed by Dr. Renn to be part of the legal definition of pneumoconiosis. While I erred in this aspect of my reasoning, I still find Dr. Renn's attempt to reason away his thirteen positive x-ray interpretations less than compelling. Dr. Renn testified that his positive ILO classifications of the films were not diagnoses, but were only indications of whether the films were consistent or inconsistent with coal workers' pneumoconiosis. As x-ray interpretations which are at least 1/0 are validly accepted as evidence of pneumoconiosis, I still accord less weight to Dr. Renn's opinion, to the extent that he has contradicted his own objective findings.

I erred in the January 7, 1998 Decision and Order by discrediting Dr. Fino's opinion on the basis that he did not examine the claimant. After careful review of his report, I find that his opinion, which is thorough and detailed in providing the basis for his conclusions in relation to the documentation and data, is very well reasoned and entitled to great weight.

Dr. Devabhaktuni opined that the claimant suffers from chronic obstructive pulmonary disease and coal workers' pneumoconiosis due to his extensive smoking history and his long term exposure to coal dust. After reconsideration, I still find Dr. Devabhaktuni's opinion to be well-reasoned and entitled to great weight.

Having carefully reconsidered the medical opinion evidence, favorable and unfavorable, I have determined that the opinions of Drs. Altmeyer and Fino are entitled to greater weight than the opinion of Dr. Devabhaktuni. Although I determined that Claimant established the existence of pneumoconiosis via the x-ray evidence, and Dr. Devabhaktuni's opinion is consistent with this finding, I cannot overlook the fact that Drs. Altmeyer and Fino's opinions both consider the presence of irregular opacities in the lower lung zones on all the x-ray films, both positive and negative. Moreover, I find that their opinions, especially Dr. Fino's, are more consistent with the other medical evidence, especially the ventilatory study findings, arterial blood gas findings, and physician examination findings.

After weighing the x-ray and medical opinion evidence together pursuant to *Compton*, I find that Claimant has not established the existence of pneumoconiosis. First, although I found that Claimant established the existence of pneumoconiosis via x-ray, the evidence was close. In addition, the majority of the better reasoned medical opinions took into consideration other factors such as the Claimant's extensive smoking history, blood gas studies, physical examinations, and other medical conditions, such as recurrent aspiration pneumonitis and chronic congestive heart failure, which could also result in irregular opacities on x-ray. (EX 13 at 19-21) Claimant must establish the existence of pneumoconiosis by a preponderance of the evidence. After weighing all of the relevant evidence together, I find that he has not done so.

Since Claimant has not established the existence of pneumoconiosis, he has failed to meet the first element of entitlement to benefits under the Act. Therefore, the claim of Robert Shuman for black lung benefits under the Act is DENIED.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in the cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for services rendered to him in pursuit of this claim.

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MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the office of the District Director, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601*. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.